Occupational Therapy Department

Outpatient Referral Questionnaire: Children 3 – 8 years

Child's Name: _____ Date of Birth: _____

Address: _____ Postcode: _____

Parent/Guardian Names: _____

Phone Number: (Home) _____ (Work) _____ (Mobile) _____

Sibling's Name/s & Age/s: _____

Who does the child live with? _____

Cultural Details: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Reason for Referral

Who suggested that your child should be assessed by an Occupational Therapist?

_____

Why? _____

_____

What do you feel are your child's main difficulties?

_____

_____

What do you feel are your child's main strengths?

_____

_____

Medical History

Name of General Practitioner: _____

Name of Paediatrician / Specialist/s: _____

Has your child been diagnosed as having any medical condition or diagnosis? Yes No

If yes, what is the diagnosis/condition? _____

Who made this diagnosis? _____

When was the diagnosis made? _____

Has you child suffered from any illnesses / injuries? (please describe)

_____

Please describe your child's general health: _____

_____

Has the following been tested?

	YES	NO	WHEN	COMMENTS
Vision				
Hearing				

Has your child been assessed or received occupational therapy previously? (please describe)

_____

_____ *Please attach any relevant reports*

Has your child received any of the following services?

	YES	NO	PLEASE DESCRIBE
Speech Pathology			
Physiotherapy			
Other			

Child Development

Pregnancy: Gestation Period: _____ Medication: _____ Smoking: _____

Birth: Birth weight: _____ Any difficulties? *(please specify)* _____

_____

Feeding: Any difficulties (eg. Sucking, swallowing, chewing)? *(please specify)* _____

_____

How do you feel your child developed compared with other children?

SKILL	EARLY	AVERAGE	LATE	COMMENTS
Rolled over				
Sat				
Crawled				
Walked				
Played with toys				
Combines words				

Communication & Behavior

Do you have any concerns regarding your child's communication skills? _____

_____

Do you have any concerns regarding your child's behavior? _____

_____

Can your child:

	YES	NO	COMMENTS
Follow instructions			
Give instructions			
Understand verbal statements			
Express themselves through language			
Interact well with other children			

Is your child:

	ALWAYS	OFTEN	AT TIMES	NEVER	COMMENTS
Friendly					
Shy					
Talkative					
Nervous					
Easy going					
Confident					
Bad tempered					
Difficult to discipline					
Aggressive					
Over reactive					
Under reactive					
Distractible					
Fussy					
Withdrawn					
Irritable					
Slow to go to sleep					
Inattentive					

Having memory difficulties					

Motor Skills

Hand preference: *(please circle)* Right Left Not Established

Does your child:

	YES	NO	COMMENTS
Draw shapes (eg. Circles/squares)			
Cut with scissors			
Manage construction games (eg. Lego, jigsaw puzzles)			
Thread beads			
Colour within lines			
Glue without a mess			
Fall or lose balance often			
Appear clumsy			
Ride a bike			
Catch a ball well			
Throw a ball well			
Hop on either leg			

Self-Care

How does your child:

	CANNOT	NEEDS HELP	INDEPENDANT	COMMENTS
Drink				
Feed				
Use spoon/fork				
Use knife				
Pour drinks				

Can your child:

	YES	NO	COMMENTS
Dress Self			
Undress			
Manage buttons/zips			
Tie shoelaces			
Take self to toilet			
Shower/Bath self			
Clean teeth			
Comb hair			

School

Name of School: _____

Year Level: _____ Name of Teacher: _____

Please describe any difficulties experienced in the classroom: _____

_____

Questionnaire completed by: _____ Relationship to child: _____

Signature: _____ Date: _____